THE RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Dear Provider,

Thank you for your interest in the Rhode Island Medical Assistance Program. Enclosed are the forms and information necessary to enroll as a performing provider within an established group. Please send those that are marked mandatory for enrollment processing:

- Group Provider Application Form
- Current copy of your practice's form of licensure

Completed enrollment forms should be mailed to:

EDS
Provider Enrollment Unit
PO Box 2010
Warwick, RI 02887-2010

If you have any questions about the enrollment form or enrollment process, please call EDS at **1-401-784-8100** for instate and long distance callers or 1-800-964-6211 for instate toll callers and border communities.

IMPORTANT NOTE: **Please DO NOT send any claims with your application.** Wait until you have received your provider number and a billing manual. If you are an out-of-state provider, wait for your provider number, manual and Prior Authorization before sending in any claims.

An incomplete application will be returned.

ENROLLMENT FORM DIRECTIONS FOR INDIVIDUALS JOINING AN ESTABLISHED GROUP

1. **GROUP NAME -** Enter your group provider name.

2. **GROUP PROVIDER NUMBER** - Enter the group provider number.

3. **ADDRESS -** Enter the service location address, pay to address and the mail to address of the group.

4. **PHONE NUMBER -** Enter the area code and telephone number of the location where business or service is conducted.

5. **GROUP'S TAX IDENTIFICATION NUMBER -** Enter your group's FEIN number (9 - digits).

A **6.** CENSUS TRACK, COUNTY CODE, TOWN CODE & LOCATION CODE - **This is filled out by EDS.**

7. **PROVIDER NAME -** Enter the provider's name.

8. **EFFECTIVE DATE -** Enter the date of service for the first encounter with a Rhode Island Medical Assistance recipient.

9. **MEDICARE NUMBER –** Enter the Medicare number that the provider will use to bill with this group. NOTE: The provider will need a new Medicare number for each group they join.

10. **LICENSE OR CERTIFICATION NUMBER -** If you are required to be licensed to provide services, enter your license or certification number. **A copy of the current valid license or certification letter must be submitted with the application.**

11. **UPIN -** Enter the Unique Physician Identification Number.

12. **TYPE & SPECIALITY –** Enter the appropriate provider type and specialty, e.g., MD – internist; DDS – Oral Surgeon.

13. **SIGNATURE & DATE** - Application must be signed by the individual applicant. Stamped or photocopied signatures are not acceptable.

14. **SIGNATURE OF PROVIDER, SENIOR PARTNER, OR CHIEF CORPORATE OFFICER OF GROUP**

EDS / Provider Enrollment Unit, P.O. Box 2010, Warwick, RI 02887-2010

Requests for updates to your provider file, such as name or address changes, must be signed by the provider or authorized administrator and sent to the address above.

An incomplete application will be returned for completion.
Avoid this delay by submitting a complete application.

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
GROUP PROVIDER APPLICATION FORM

Group Name:_____

Service Location Address: _____

_____

Pay To Address: _____

_____

Mail To Address: _____

_____

Group Provider Number:_____

Phone Number: _____

Group's Tax Identification Number: _____

shaded is EDS use only

Census Track: _____

County Code: _____

Town Code: _____

Location Code:_____

NEW GROUP MEMBERS:

I understand fully the standard of participation as stated in the State of Rhode Island, Department of Human Services, Provider Agreement Form (enclosed in enrollment packet) and will participate in the Rhode Island Medical Assistance Program in accordance with these standards.

NAME	EFF DATE w/GRP	MEDICARE PROVIDER #	UPIN #	LICENSE #	TYPE & SPECIALTY	SIGNATURE	DATE

_____

A Signature of Provider, Senior Partner, or Chief Corporate Officer of Group Title Date

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE FOR EACH GROUP MEMBER LISTED*****
PLEASE LIST ADDITIONAL GROUP PROVIDERS ON NEXT PAGE

BELOW LIST ADDITIONAL GROUP MEMBERS JOINING:

NAME	* EFF DATE	MEDICARE PROVIDER #	UPIN #	LICENSE #	TYPE & SPECIALTY	SIGNATURE	DATE

PLEASE FURNISH A COPY OF THE CURRENT LICENSE FOR EACH GROUP MEMBER LISTED